General Medicine/Rheumatology Ward C5

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Welcome to ward C5

I hope you will both enjoy and benefit from your attachment on Ward C5. Experience suggests that what you get out of the attachment depends on what you put in, with lots of opportunities for learning clinical and practical skills. I have written these notes to give you an idea of what will be expected of you but also to help you get the most out of your attachment. The in-patient work is predominantly general internal medicine with a flavouring of Rheumatology. The outpatient workload is more speciality oriented. To get the most out of your attachment it is important that you do some background reading around this speciality and regularly check your management plans against those in your DGRI Doctor's handbook. We have access to uptodate on the ward and by reading around clinical cases you will consolidate your knowledge

Co-ordination of patient care

Review your patients daily or ensure one of your colleagues does this if you cannot do it yourself. Keep up to date about the progress of other assessments, such as social work and occupational therapy. Write daily follow-up notes detailing the problem list, results of investigations, treatment changes, (including the reason for those changes), and the response to treatment. All case note entries must be neat and legible with time, date, signature and clearly printed name with contact phone number. Keep focussed….it will make discharge summaries easier to do. You must check results on a daily basis.

There are ward huddles, which you must attend at 9 am and 1.30 pm.

You set aside time for administrative duties including doing discharge letters. Never let these build up……they are much harder to do after a delay. Try and keep them succinct and remember they are correspondence to the GP and a summary of events in the case notes so think what will be useful to know should the patient ever be readmitted. There is no point in writing a letter which states just "I have nothing to add to the IDL." I am quite happy if the IDL clearly summarises the case that you merely add to the information eg " the results of the MSU we were waiting for showed...".

I would like you to quickly visit each patient in the afternoon to tell them their results from that day, even if this is only to say "your blood count today is fine" Talking to relatives about the patient's course and discharge plans is very important. Please record comments made to relatives and ensure that the patient has given consent first. You must speak directly to the nurse in charge at the end of your ward round to clarify plans for all out patients.

The consultant ward round

This is the focal point of the ward week both for clinical care and training. Attendance is mandatory and you should only leave with the consultant's permission. You are responsible for presenting every case. You may delegate some presentations to the FY1 or medical students if they have been involved in the case and are present but should be ready to fill in any missing points yourself. You should identify the important problems clearly. The most useful approach is to present the case, list the problems as you see them, and outline how you would address each one. We can then discuss the plan. If you are unsure about any point this is the time to clarify it and you must inform the consultant if you have been asked to do something outwith your experience. The consultant ward rounds are either Monday or Tuesday morning and Friday morning.

Out-patient clinics

You should aim to attend at least one clinic per week. Either Wednesday morning or Thursday Morning are the best to attend. The former is a mix of new and review and the latter mainly inflammatory arthritis follow-ups. Because the ward work is mainly general medicine, you will only get rheumatology exposure by attending a clinic. I do not mind if you see the ward patients before coming down to clinic, or if you prefer to leave early if ward work requires it.

To get the most out of a clinic it is best that you do a little reading before attending and have a basic idea both of what is going on and what you need to learn. I've listed some musculoskeletal competences (from the RCP Physician of tomorrow document), at the end of this handout.

Education:

You should attend the departmental grand rounds (Wednesday) and Journal clubs (Friday). There will be additional reading and discussion on ward round days. Every two months we have a combined mortality and morbidity meeting for which you will be expected to review case notes and present salient details. This should be a learning experience for everyone and must be performed in a non-critical but questioning manner.

Clerical matters:

Immediate discharge summaries should be prepared prior to discharge so as not to delay discharges unnecessarily. Formal discharge summaries should be dictated within 24 hours of the patient's discharge or at the latest by the following Monday. Set aside time for this. You might find it useful to set aside one hour on Monday afternoons to catch up with dictation etc. Arrange with the other ward SHOs to cover each other for an hour each so you can get this done without being disturbed. When patients are transferred to other hospitals, including community hospitals, formal discharge summaries must go with them.

Some general points:

You should be on the ward ready to start work at 9.00 am, having to attend the morning huddle. You must give adequate warning of any planned absences including GP training events and ensure that ward duties are covered. Tell us early on if you are doing exams and we can arrange appropriate teaching. We would expect you to help each other if one team are quiet…expecting this to be reciprocated. You should attend **any** acutely unwell patient on the ward immediately if asked by a member of the nursing team, until a member of that team can be located.

The FY1 on ward C5 rotates between the teams. Their priority is to know all the patients under their Consultant team but can assist with administrative duties for the other teams. Do not however delegate tasks such as PR examinations on patients they have not seen nor should they be doing all the discharge letters.

Musculoskeletal Competences

Competencies

- Accurately describe the examination features of musculoskeletal disease following full assessment
- Recognise when specialist Rheumatology opinion is indicated
- Outline the indications, contraindications and side effects of the major immunosuppressive drugs used in rheumatology including corticosteroids
- Recognise the need for long term review in many cases of rheumatological disease and their treatments
- Recognise importance of eg multidisciplinary approach to rheumatological disease including physio, OT
- Use local / national guidelines appropriately e.g. osteoporosis

Common or Important Problems:

- Septic arthritis
- Rheumatoid arthritis
- Osteoarthritis
- Seronegative arthritides
- Crystal arthropathy
- Osteoporosis – risk factors, and primary and secondary prevention of complications of osteoporosis
- Polymyalgia and temporal arteritis
- Acute connective tissue disease: systemic lupus erythematosus, scleroderma, poly and dermatomyositis, Sjogren's syndrome, vasculitides

Clinical Science:

- Structure and function of muscle, bone, joints, synovium
- Bone metabolism
- Pharmacology of major drug classes: NSAIDS, corticosteroids, immunosuppressants, colchicines, allopurinol, bisphosphonates

That is quite a long list but, ask yourself how you would diagnose the common disorders, assess their severity and what standard treatment would be. Here are some SIGN guidelines to look at:

- SIGN 142 Management of osteoporosis and the prevention of fragility fractures
- SIGN 123 Management of early rheumatoid arthritis
- SIGN 121 Diagnosis and management of psoriasis and psoriatic arthritis in adults